SCOTT ORTHOPEDIC CENTER INITIAL MEDICAL HISTORY

PATIENT'S NAME: ______________________________

WHY ARE YOU SEEING THE DOCTOR TODAY? ______________________________
WHICH BODY PART ARE YOU SEEING THE DOCTOR FOR TODAY? ______________________________
PAIN SCALE TODAY 1-10 (10 BEING THE WORST POSSIBLE PAIN)? ______________

CHIEF COMPLAINT

WHAT ARE YOU ALLERGIC TO? ______________________________

WHAT MEDICINES ARE YOU TAKING? *** (IF YOU HAVE A LIST, SKIP THIS PART AND GIVE LIST TO THE NURSE)**
WHAT PHARMACY DO YOU NORMALLY USE? ______________________**(LOCATION?)**______________

NAME OF MEDICINE	DOSAGE	HOW OFTEN

CURRENT MEDICATION

WHO IS YOUR PRIMARY CARE DOCTOR AND WHERE ARE THEY LOCATED? ______________________________

DO YOU HAVE ANY OF THESE CONDITIONS?

HEART PROBLEMS	YES	NO	CIRCULATION PROBLEMS	YES	NO	
HIGH BLOOD PRESSURE	YES	NO	HEPATITIS OR JAUNDICE	YES	NO	
DIABETES	YES	NO	ASTHMA	YES	NO	
ULCERS	YES	NO	IBS/DIVERTICULITIS	YES	NO	SPECIFY: __________
LUNG PROBLEMS	YES	NO	ANXIETY/DEPRESSION/BIPOLAR	YES	NO	SPECIFY: __________
ARTHRITIS	YES	NO	THYROID (CHOOSE ONE)	HYPER	HYPO	
CHOLESTEROL	YES	NO	(OTHER)__________________			
CANCER*	YES	NO	*(Type of cancer?) ______________			

REVIEW OF SYSTEMS

DESCRIBE PAST SURGERIES OR HOSPITALIZATIONS: (IF YOU HAVE A LIST, SKIP THIS PART AND GIVE LIST TO THE NURSE)

WHAT	WHEN

SURGICAL HISTORY

DO YOU SMOKE?	YES	NO	
HAVE YOU EVER USED ILLEGAL DRUGS?	YES	NO	**WHAT?** __________ / **WHEN?** __________
DO YOU DRINK ALCOHOL?	YES	NO	**AMOUNT?**__________**/PER**__________

WHERE DO YOU RESIDE/LIVE? (CIRCLE ONE) HOME PARENTS WITH A FRIEND NURSING HOME OTHER:______________

SOCIAL HISTORY

WHAT ILLNESSES OR MEDICAL PROBLEMS RUN IN YOUR FAMILY? ______________________________

____

ARE YOUR PARENTS STILL LIVING?	**MOTHER**	YES	NO	____________________(MEDICAL HISTORY)
	FATHER	YES	NO	____________________(MEDICAL HISTORY)

FAMILY HISTORY

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE:

PATIENT OR GUARDIAN SIGNATURE ______________________________ **DATE:** ______________

REVIEWED BY PHYSICIAN: ______________________________,MD **DATE:** ______________